DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 9 4 — 0 2 2

2. STATE: Missouri

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
June ~~18~~ 30, 1994

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447

7. FEDERAL BUDGET IMPACT:
a. FFY 1994 ($19,359) savings
b. FFY 1995 ($92,697) savings

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-A
Page ~~[illegible]~~, ~~[illegible]~~, ~~[illegible]~~, ~~[illegible]~~, ~~[illegible]~~, 12c~~and~~, 12d
~~Appendix B,~~ and 20a

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-A
Page ~~[illegible]~~, ~~[illegible]~~, ~~[illegible]~~, ~~[illegible]~~, ~~[illegible]~~, ~~[illegible]~~, ~~[illegible]~~, ~~[illegible]~~ 20a

10. SUBJECT OF AMENDMENT: Hospital Services Reimbursement plan change implemented durin the April - June 1994 quarter. Plan change consolidates and restricts DSH criteria, expands Safety Net provision, implements OBRA 93, and defines inpatient and out patient settlement process.

11. GOVERNOR'S REVIEW *(Check One)*:

☑ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Gary J. Stangler

14. TITLE:
Director, Department of Social Services

15. DATE SUBMITTED:
June 28, 1994

16. RETURN TO:
Missouri Department of Social Services
Division of Medical Services
P. O. Box 6500
Jefferson City , Missouri 65102-6500

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
06/30/94

18. DATE APPROVED:
AUG 28 2001

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
06/30/94

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Nanette Foster Reilly

22. TITLE:
Acting ARA for Medicaid & State Operations

23. REMARKS:
cc:
Martin
Vadner
Waite

SPA CONTROL
Date Submitted 6/29/94
Date Received 6/30/94

FORM HCFA-179 (07-92)

Instructions on Back

D. Disproportionate Share Payment Limitation. In accordance with OBRA 93, disproportionate share payments shall not exceed one hundred percent (100%) of the cost of services for Medicaid and the uninsured. This limitation is effective for all public hospitals beginning with SFY 95, except for "High DHS" which are limited to two hundred percent (200%) of cost for SFY 95. The one hundred percent (100%) limitations is effective for all hospitals beginning with SFY 96.

1. Definitions.

(a) Disproportionate share payments - Per-diem payments in excess of the general plan rate and payments for uncompensated care. Disproportionate share payments include UCACI, safety net, MMCP and the MMCP incentive payment paid to the hospitals that have at least 1% Medicaid utilization rate for Medicaid eligible recipients.

(b) High DSH - A public hospital with a Medicaid inpatient utilization rate greater than one (1) standard deviation above the standard mean. For the purpose of this subsection only the term "Medicaid inpatient utilization rate" means a fraction (expressed as a percentage) the numeration of which is the hospitals' nuber of inpatient days attributable to patients who (for such days) were eligible for medical assistance under a State Plan, and the denominator of which is the total number of the hospital's inpatient days in that period.

(c) Public hospital - A hospital owned or operated by a state, city or local governmental agency.

(d) Uncompensated care cost - Uncompensated care cost is calculated by multiplying the estimated Medicaid patient days by the Medicaid trended cost per day plus estimated Medicaid outpatient costs minus estimated inpatient and outpatient claims payments, plus the cost of services provided to uninsured patients. The cost of service provided to insured patients is calculated by multiplying the hospital's charity care and bad debt charges by the hospital's base period cost-to-charge ratio. Bad debts used in the Uncompensated care costs should include the costs of caring for patients who have insurance but are not cover the particular services, procedures or treatment rendered. Bad debts should not include the cost of caring for patients whose insurance covers the given procedures buts limits coverage. In addition, bad debts should not include the cost of caring for patients whose insurance covers the procedure although the total payments to the hospital are less than the actual cost of providing care.

Medicaid and uninsured cost

Days x Trended Cost per day	100 x $365 =	$36,500
O/P payments ÷ payment %	$4,000 ÷ 80% =	5,000
Uninsured Cost *(charity care & bad debt x cost-to-charge ratio)*	($5,000 + $2,000) x .4 =	2,800
Total Medicaid and uninsured cost		$ 44,300
Estimated Claims payment		(34,000)
Uncompensated care costs		$ 10,300

2. Computation of disproportionate share limitation. Public hospitals, other than High DSH shall be limited to one hundred percent (100%) of this uncompensated care cost for SFY 95. High DSH shall be limited to two hundred percent (200%) for SFY 95. All hospitals shall be limited to one hundred percent (100%) of the estimated uncompensated care cost beginning with SFY 96.

3. If the sum of disproportionate share payments exceeds the estimated uncompensated care cost, the difference shall be deducted in order as necessary from the safety net payment, UCACI payment, other disproportionate share lump sum payments, and if necessary as a reduced per diem.

D. In compliance with 42 CFR 447.253(b)(2), the Division of Medical Services shall make a finding each State fiscal year to ensure that estimated aggregate Title XIX payments do not exceed the estimated upper limits described in 42 CFR 447.272. Should the Division's finding indicate the estimated upper payment limit will be exceeded, the Division will take corrective action to reduce Title XIX payments to the estimated upper limit.

XVIII. Safety Net Adjustment. A Safety Net Adjustment shall be provided for each hospital which qualified as disproportionate share under the provision of VI.D.3.(e) prior to the end of each state fiscal year.

A The Safety Net Adjustment shall be computed as follows:

1. The Safety New Adjustment shall be equal to the lesser of charity care charges or total unreimbursed hospital charges. Unreimbursed hospital charges are computed as total hospital charges less patient revenues and UCACI adjustments computed in accordance with subsection XVI.B. In the case of nominal charge providers whose total charges are less than cost, total hospital costs shall be substituted for total hospital charges.

2. If the aggregate cash subsidies (CS) are less than the matching amount required, the total aggregate safety net adjustment will be adjusted downward accordingly, and distributed to the hospitals in the same proportions as the original safety net adjustments.

3. The data sources, reports and data definitions for determining the Safety Net Adjustments shall be the same as described in paragraph VI.A.2 and adjusted as may be described above. Hospitals which do not have a third prior fiscal year cost report described in paragraph VI.A.2. shall not be eligible for a safety net adjustment. No amended cost reports shall be accepted after the Division's annual determination of the adjustment amount.

4. Adjustments provided under this section shall be considered reasonable costs for purpose of the determinations described in paragraph V.D.2.

B. A safety net adjustment described in this section shall be available to a children's hospital.

C. A Safety Net adjustment described in this section shall be available to sole community hospitals defined in paragraph V.E.4.

"Substitute per letter dated 6/12/01"

INSTITUTIONAL STATE PLAN AMENDMENT
ASSURANCE AND FINDING CERTIFICATION STATEMENT

STATE: Missouri TN - 94-22

REIMBURSEMENT TYPE: Inpatient hospital X

PROPOSED EFFECTIVE DATE: June 30, 1994

A. State Assurances and Findings. The State assures that is has made the following findings:

1. 447.253 (b) (1) (i) - The State pays for inpatient hospital services through the use of rates that are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers to provide services in conformity with applicable State and Federal laws, regulations, and quality and safety standards. _____

2. With respect to inpatient hospital services - -

   a. 447.253 (b) (1) (ii) (A) - The methods and standards used to determine payment rates take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs. _____

   b. 447.253 (b) (1) (ii) (B) - If a state elects in its State plan to cover inappropriate level of care services (that is, services furnished to hospital inpatients who require a lower covered level of care such as skilled nursing services or intermediate care services) under conditions similar to those described in section 1861 (v) (1) (G) of the Act, the methods and standards used to determine payment rates must specify that the payments for this type of care must be made at rates lower than those for inpatient hospital level of care services, reflecting the level of care actually received, in a manner consistent with section 1861 (v) (1) (G) of the Act. _____

   If the answer is "not applicable," please indicate:

   _____

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c. 447.253 (b) (1) (ii) (C) - The payment rates are adequate to assure that recipients have reasonable access, taking into account geographic location and reasonable travel time, to inpatient hospital services of adequate quality. _____

4. 447.253 (b) (2) - The proposed payment rate will not exceed the upper payment limits as specified in 42 CFR 447.272:

a. 447.272 (a) - Aggregate payments made to each group of health care facilities (hospitals, nursing facilities, and ICFs/MR) will not exceed the amount that can reasonably be estimated would have been paid for those services under Medicare payment principles. _____

b. 447.272 (b) - Aggregate payments to each group of State-operated facilities (that is, hospitals, nursing facilities, and ICFs/MR) - - when considered separately - - will not exceed the amount that can reasonably be estimated would have been paid for under Medicare payment principles. _____

If there are no State-operated facilities, please indicate "not applicable:"

_____

c. 447.272 (c) - Aggregate disproportionate share hospital (DSH) payments do not exceed the DSH payment limits at 42CFR 447.296 through 447.299.

d. Section 1923 (g) _ DSH payments to individual providers will not exceed the hospital-specific DSH limits in section 1923(g) of the Act. _____

B. State Assurances. The State makes the following additional assurances:

1. For hospitals - -

a. 447.253 (c) - In determining payment when there has been a sale or transfer of the assets of a hospital, the State's methods and standards provide that payment rates can reasonably be expected not to increase in the aggregate solely as a result of changes of ownership, more than payments would increase under Medicare under 42 CFR 413.130, 413.134, 413.153 and 413.157 insofar as these sections affect payment for depreciation, interest on capital -indebtedness, return on equity)if applicable), acquisition costs for which payments were previously made to prior owners, and the recapture of depreciation.

3. 447.253 (e) - The State provides for an appeals or exception procedure that allows individual providers an opportunity to submit additional evidence and receive prompt administrative review, with respect to such issues as the State determines appropriate, of payment rates. _____

4. 447.253 (f) - The State requires the filing of uniform cost reports by each participating provider. _____

5. 447.253 (g) - The State provides for periodic audits of the financial and statistical records of participating providers. _____

6. 447.253 (h) - The State has complied with the public notice requirements of 42 CFR 447.205.

Notice published on: June 17, 1994
If no date is shown, please explain:

_____

_____

_____

7. 447.253 (i) - The State pays for inpatient hospital services using rates determined in accordance with the methods and standards specified in the approved State plan. _____

C. Related Information

1. 447.255 (a) - NOTE: If this plan amendment affects more than one type of provider (e.g., hospital, NF, and ICF/MR; or DSH payments) provide the following rate information for each provider type, or the DSH payments. You may attach supplemental pages as necessary.

Provider Type: Hospital

For hospitals: The Missouri Hospital Plan includes DSH payments in the estimated average rates. However, the DSH payments included in the estimated average rates do not represent the total DSH payments made to hospitals under the Missouri Medicaid Plan.

RH-DSH included

Estimated average proposed payment rate as a result of this amendment: $ 647.18

Average payment rate in effect for the immediately preceding rate period: $647.18

Amount of change: $0.00 Percent of change: 0.0%

Estimated average proposed out-of-state payment rate as a result of this amendment: $ 432.17

Average out-of-state payment rate in effect for the immediately preceding rate period: $432.17

Amount of change: $0.00 Percent of change: 0.0%

Estimated DSH payments not in average payment rate as a result of this amendment: $ 714.94

Estimated DSH payments not in average payment rate immediately preceding amendment: $ 714.94

Amount of change: $0.00 Percent of change: 0.00%

2. 447.255 (b) - Provide an estimate of the short-term and, to the extent feasible, long-term effect the change in the estimated average rate will have on:

(a) The availability of services on a statewide and geographic area basis: This amendment will not effect the availability of short-term or long-term services.

(b) The type of care furnished: This amendment will not effect hospital services furnished to Medicaid eligibles.

(c) The extent of provider participation: This amendment will assure recipients have reasonable access taking into account geographic location and reasonable travel time to inpatient hospital services.

(d) For hospitals - - the degree to which costs are covered in hospitals that serve a disproportionate number of low income patients with special needs: It is estimated that disproportionate share hospitals will receive 100% of its Medicaid cost for low income patients with special needs.